Maximizing Enrollment for Kids: Results from a Diagnostic Assessment of Enrollment and Retention in Eight States

Maximizing Enrollment for Kids Diagnostic Assessment Reports

By

Jennifer Edwards, Lisa Duchon, Eileen Ellis, Caroline Davis, Rebecca Kellenberg and Jodi Bitterman
Health Management Associates

With
Catherine Hess and Alice Weiss
National Academy for State Health Policy

February 2010

A product of the Maximizing Enrollment for Kids program

NATIONAL ACADEMY *for* STATE HEALTH POLICY

Robert Wood Johnson Foundation

This report is a product of the Maximizing Enrollment for Kids program, a $15 million initiative of the Robert Wood Johnson Foundation (RWJF) to increase enrollment and retention of children who are eligible for public health coverage programs like Medicaid and the Children's Health Insurance Program (CHIP) but not enrolled. Under the direction of the National Academy for State Health Policy (NASHP), which serves as the national program office, Maximizing Enrollment for Kids aims to help states improve their systems, policies and procedures to increase the proportion of eligible children enrolled and retained in these programs.

Acknowledgements

The authors wish to thank the Robert Wood Johnson Foundation (RWJF) for its support of this report and in particular Deborah Bae, Program Officer, Brian Quinn, Program Officer, and Andrew Hyman, Team Director and Senior Program Officer. We also thank the many state Medicaid and CHIP officials in each of the eight states participating in the Maximizing Enrollment for Kids program who participated in interviews, provided extensive program data and background materials and completed detailed questionnaires and process maps contribute to this assessment. This report could not have been completed without their participation and enthusiasm.

Additionally, we are indebted to the program staff, supervisors and managers who met with us during site visits and to state officials in public health, social services, education and other agencies, as well as advocates, providers and leaders of community-based organizations and foundations who provided their perspective and insights. The diagnostic assessment and this report benefited from the support and input of a number of individuals at NASHP including Alan Weil, Neva Kaye, Maureen Hensley-Quinn, Jennifer May and Amanda Wyatt; as well as key external advisers of the Maximizing Enrollment for Kids program.

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Executive Summary

In June of 2008, the Robert Wood Johnson Foundation (RWJF) launched *Maximizing Enrollment for Kids*, a $15 million national initiative to help states increase enrollment and retention of eligible children in Medicaid and CHIP and establish and promote best practices among states. In February of 2009, eight states were selected through a competitive application process and National Advisory Committee review to participate in *Maximizing Enrollment for Kids*: Alabama, Illinois, Louisiana, Massachusetts, New York, Utah, Virginia, and Wisconsin. The National Academy for State Health Policy (NASHP) is the national program office for *Maximizing Enrollment for Kids*, providing technical assistance and direction for the program. Through *Maximizing Enrollment for Kids*, RWJF and NASHP are partnering to assist states to better understand the strategies that will help them to enroll and retain more eligible uninsured children and to measure their progress over time. The program also includes a detailed evaluation that will help grantees and other policymakers understand the impact of the initiatives implemented through *Maximizing Enrollment for Kids.*

Each grantee state will receive four-year grants of up to $1 million, along with targeted technical assistance to help them achieve transformative, systemic changes in their enrollment and retention systems, policies and procedures for children. Each of these grantee states has a strong track record of improving children's coverage, and each state's governor has made a commitment to achieve new enrollment and retention goals for children as part of participation in this program. For more information about *Maximizing Enrollment for Kids*, please visit the program's website at www.maxenroll.org.

As part of this first year of the program, *Maximizing Enrollment for Kids* has worked with grantee states to conduct a diagnostic assessment to identify the strengths and weaknesses of the states' Medicaid and CHIP enrollment and retention systems. The diagnostic assessment, which was conducted in the beginning half of 2009, required grantee states to complete a structured questionnaire, map their enrollment and renewal processes, participate in a site visit, and supply documents and data for review by Health Management Associates, which conducted the assessment in partnership with NASHP. As part of the assessment, each state received an individualized report summarizing key strengths, challenges and opportunities for improvement in the state's enrollment and retention systems, policies and procedures for children.

The economic and political environment at the time of this assessment (February - June 2009) was important context for the assessments and this report. During the development and implementation of the diagnostic assessment protocol in late 2008 and throughout the spring of 2009, the United States was in a deep recession with high unemployment leading to a greater demand for public health insurance coverage. State budgets were greatly depressed; nearly every state faced a budget shortfall. The outlook in 2009 was for continued budget shortfalls for the next three years. Several states were furloughing employees and all states were seeking to serve more children with the same or smaller staff. At the same time, state programs were supported by the enactment of the Children's Health Insurance Program Reauthorization Act (CHIPRA) and the American Recovery and Reinvestment Act (ARRA) in February of 2009, both of which provided states with new investments and incentives for improving coverage for children in Medicaid and CHIP.

Despite the drastic economic circumstance and significant changes in political leadership among some grantee states during the assessment period, the diagnostic assessment found that all eight states showed a strong and continuing commitment to maintaining and increasing enrollment of eligible children. In some cases, states also expanded public health insurance coverage programs for low-income children.

Results of the assessment revealed a mix of shared and unique strengths and challenges among grantee states in their efforts to maximize enrollment for children. This report highlights those strengths and challenges, as well as opportunities, which emerged as four central themes:

1. Process Improvement and Paperwork Reduction

Making enrollment and renewal processes simple to follow with little or no burden on families to produce documentation are vital steps in improving children's enrollment in public health insurance coverage programs. Simple processes also reduce the paperwork burden on busy program staff. Most grantee states have adopted a number of enrollment and renewal simplification strategies that other states may want to model, including:

- Self-declaration of income;
- Third-party data matching;
- Electronic signature;
- Electronic case records;
- Annual renewal;
- Twelve-months continuous eligibility; and
- Ex parte and administrative renewal.

However, many grantee states also faced common challenges in their efforts to reduce paperwork and make enrollment and renewal less burdensome for families and more efficient for state agencies and workers. These included:

- Systems constraints, often in the form of computer mainframe "legacy" systems, with their limited automation and electronic exchange capabilities;
- Structural constraints, as a result of complex organizational arrangements that may require significant coordination among multiple agencies to share and exchange data; and
- Limitations of technological innovations, because there will always be families struggling with literacy, language, or the complexities of their daily lives, and will need "human touch" assistance with enrollment and renewal.

Grantee states also shared a number of common opportunities to improve enrollment and renewal processes. Key steps they and other states can consider include:

- Estimate system costs for processes identified as potential bottlenecks;
- Seek input from stakeholders to better understand problem areas and set priorities;

- Invest in system improvements identified as having a high productivity payoff; and
- Focus special attention on retention strategies to reduce "churning" rates of children terminated from the program who reapply within 60 to 90 days.

2. Data Analysis and Integration

Data analysis and integration of information systems are helping grantee states to identify problems, target their efforts, and monitor their performance, all of which are key components of process improvement. Developing performance measures for enrollment and retention outcomes can help states identify successful enrollment and renewal strategies. The ability to track children over time as they move across programs and out of coverage was another common strength among grantee states. Other key strengths among some grantee states included having:

- An infrastructure for data analysis;
- Actionable performance measures;
- Use of a single identifier across programs;
- Single or compatible information systems across sites; and
- Electronic case records.

Common challenges identified among grantee states, which generally related to the system and structural constraints highlighted above, included:

- Lack of a single identifier across programs;
- Multiple, disconnected information systems;
- Legacy mainframe computer systems;
- Lack of standard or actionable measures;
- Competing priorities for the staff time of information technology specialists; and
- Lack of refined data on characteristics of uninsured children.

Even in the face of these significant challenges, the assessments identified a number of incremental steps grantee states can take to improve their data analysis capabilities, with the ultimate goal of making more informed management, operations and policy decisions. The assessment identified the following opportunities:

- Set an analytic agenda and create measures to support it;
- Target children known to the system for outreach;
- Collect, analyze and report existing data for key audiences to improve state monitoring of impact of enrollment and retention strategies and build support for maintaining and investing in improvements;
- Build constituencies for change;
- Seek support for cross-agency initiatives; and

- Seek opportunities for federal grants to improve systems capacities available through the Children's Health Insurance Program Reauthorization Act (CHIPRA) and the American Recovery and Reinvestment Act (ARRA)/Health Information Technology for Economic and Clinical Health Act (HITECH).

3. Leadership Capacity, Agency Coordination and Culture

All states participating in the *Maximizing Enrollment for Kids* Program demonstrated positive effects of leadership, agency capacity, coordination and culture on children's coverage. In different ways, policy leaders, including the governor, legislature, and agency heads in grantee states have demonstrated their commitment to children's coverage by making it a priority, allocating and maintaining resources even during periods of economic adversity, and promoting inter-agency cooperation. Other related strengths among many grantee states included having:

- Simple organizational structures to facilitate policy alignment;
- Technology that supports coordination across programs;
- Processes for transferring applicant information;
- Accountability and recognition throughout the organizational structure;
- A culture of continuous quality improvement; and
- Third-party data matching capabilities.

Many grantee states' challenges in this area emanated from competing priorities and resource constraints among or within agencies involved with children's health coverage. In grantee states with separate Medicaid and CHIP programs there may be different attitudes toward each program among state executive or legislative leaders. Other challenges included:

- Lack of alignment of policies or procedures between or among programs, such as different eligibility review;
- Staffing constraints, such as high caseloads per eligibility worker;
- Local variation across the state in how policies are implemented; and
- Information technology support located in a separate agency or available through a statewide agency with competing priorities.

Grantee states can further leverage leadership capacity, interagency coordination and culture to improve enrollment and retention included by pursuing the following opportunities to:

- Adopt "Express Lane" enrollment, ex parte renewal, and other forms of inter-agency collaboration to identify and enroll or renew eligible children;
- Seek additional leadership support at the cabinet or legislative level to facilitate inter-agency coordination;
- Implement simplifications that save staff time, such as renewal strategies designed to reduce churning;
- Continue to build on efforts to define and communicate expectations to all staff;
- Centralize some enrollment and retention functions and

- Monitor transfers between Medicaid and CHIP, using available data and analytic tools, including process maps.

4. Consumer, Community and Stakeholder Engagement

Grantee states appear to have found success in enrollment by recognizing that entities outside of government play critical roles in enhancing enrollment, including bringing family perspectives to policy and procedural issues, helping families enroll and renew coverage, generating political support for coverage programs, and providing analysis to support further program improvements. All grantee states have demonstrated promising strategies for partnering with outside entities. Strategies that appeared to be influential included:

- Engaging community partners to provide outreach, enrollment, and renewal assistance;
- Providing an environment and infrastructure for policy discussions among key stakeholders;
- Seeking consumer input periodically about how well the program works for families, and when planning or implementing new initiatives; and
- Partnering with state or local foundations, universities or other entities for support with data analysis and outreach.

Most of the challenges identified during the assessment relating to grantee states' experience with external stakeholders dealt with limited availability of resources or organizations in particular parts of the state or financial constraints of existing community-based organizations. Other challenges included:

- Data, technological, and other limitations of school partnerships to identify and ultimately enroll eligible children;
- Partnering with hard-to-identify or underserved groups, including Native American tribes, rural families and children living with non-custodial parents; and
- From some advocates' perspective, a lack of regular opportunities to meet with program officials.

Key opportunities grantee states may want to pursue to increase their engagement with external stakeholders include:

- Collaborate with community partners to develop ways to shift some of their resources to renewal efforts;
- Seek additional outreach funds through CMS or local, state or national foundations;
- Engage consumers directly in developing strategies to simplify and streamline enrollment or renewal;
- Schedule periodic meetings with stakeholders, if this is not already occurring, to exchange information about program concerns;
- Assess potential for partnerships with providers serving as medical homes as a means to increase their interest and support for ensuring eligible children retain coverage at renewal; and

- Evaluate the effectiveness of new initiatives, with support from foundations or researchers to enhance program decision-making and legislative support.

The *Maximizing Enrollment for Kids* program will build on the lessons learned from the diagnostic assessment of the grantee states in its work with the states over the next three years, working with the states to address the challenges they face and pursue the opportunities identified here. These common themes thus provide a foundation for the work of the program and a roadmap for the path forward as the program seeks to create system changes to promote enrollment and retention of uninsured children in these states, and across the nation.

The lessons identified here also may be instructive as policymakers develop and implement national health system reform. As states and the federal government seek new strategies to identify, enroll, and retain new populations and those currently eligible into expanded public health coverage programs and new subsidies, this report offers much critical information about the benefits of simplification, the importance of sound data collection and monitoring systems and strategies, the vital role that leadership and agency relationships and culture play, and the added value of involving consumers, community organizations and other stakeholders in the process. It also notes some of the challenges even leading states' public coverage systems continue to face, identifying pitfalls that new coverage systems should seek to redress and avoid where possible.

Introduction

An estimated five million children in the United States may be eligible for but not enrolled in Medicaid or CHIP programs in their state[1]. *Maximizing Enrollment for Kids*, a national program of the Robert Wood Johnson Foundation (RWJF), aims to help states increase enrollment and retention of eligible children in Medicaid and CHIP, and promote promising practices among states. The National Academy of State Health Policy (NASHP) serves as the national program office for *Maximizing Enrollment for Kids*, providing technical assistance and direction for the program.

To achieve these goals, the program includes:

- A standardized diagnostic assessment of participating states' enrollment and retention systems, policies and procedures, to determine states' strengths, challenges, and opportunities in their children's coverage efforts;
- Tailored technical assistance to help states develop and implement plans to increase enrollment and retention of eligible children, consistent with the findings of the assessment, and to measure their progress; and
- Participation in peer-to-peer exchange to share information regarding challenges and discuss solutions and effective strategies with other states.

Through a competitive application process, eight states were selected in early 2009 to receive four-year grants of up to $1 million to participate in the program: Alabama, Illinois, Louisiana, Massachusetts, New York, Utah, Virginia, and Wisconsin. The states selected have shown a strong commitment to increasing children's enrollment in public coverage programs even in the face of difficult economic times and changes in political leadership. NASHP contracted with Health Management Associates to partner in developing and conducting the diagnostic assessment of the grantee states. The diagnostic assessment required grantee states to complete a structured questionnaire, map their enrollment and renewal processes, participate in a site visit, and supply documents and data for review. The areas of focus for the diagnostic assessment and its content were informed by a literature review performed by NASHP in 2008 and input from state and national policy experts.[2]

This paper reports the findings from the diagnostic assessment in the eight states. It is organized by the four main themes of states' work identified through that process, and presented as strengths, challenges and opportunities in each area:

1. Process Improvements and Paperwork Reduction
2. Data Analysis and Integration
3. Leadership and Agency Capacity, Coordination and Culture
4. Consumer, Community Partner and Stakeholder Engagement

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[1] Dubay, L., A. Cook, and B. Garrett. "How Will Uninsured Children Be Affected by Health Reform?" Washington, DC: Kaiser Commission on Medicaid and the Uninsured, (RWJF, August 2009).

[2] Wachino, V. and A. Weiss, Maximizing Kids' Enrollment in Medicaid and CHIP: What Works in Reaching, Enrolling and Retaining Eligible Children (NASHP, February 2009).

The economic and political environment at the time of this assessment (February - June 2009) is important context for this report. During the development of the assessment protocol in late 2008 and throughout the spring of 2009, the United States was in a deep recession with high unemployment leading to a greater demand for public health insurance coverage. State budgets were greatly depressed; nearly every state faced a budget shortfall. The outlook was for continued budget shortfalls for the next three years. Several states were furloughing employees and all states were seeking to serve more children with the same or smaller staff.

On February 4, 2009, Congress passed the Children's Health Insurance Program Reauthorization Act (CHIPRA), a law reauthorizing the Children's Health Insurance Program (CHIP) until 2013, increasing funding for the program and outreach activities for eligible but unenrolled children and creating new financial incentives for states that increase enrollment and adopt key enrollment simplification strategies. Two weeks later on February 17, 2009, Congress passed the American Recovery and Reinvestment Act (ARRA) to help buffer the impact of the recession on individuals and states. Medicaid relief for 2008, 2009 and 2010 was included, contingent upon states not reducing Medicaid eligibility levels from 2008 levels.

The tension of the recession and the opportunities to obtain new funding for simplifications and expansions serve as a significant backdrop for the state assessments.

Additionally, as the diagnostic phase of the project winds down and the technical assistance phase of *Maximizing Enrollment for Kids* begins, grantee states were developing and implementing plans to increase enrollment and retention of eligible children in a climate of national debate about options for major federal health care reform. Both the House and Senate reform proposals would dramatically change the federal structure within which state health policy operates. Because states will play a critical role in the implementation of any federal health care reform, it will add an additional layer of complexity and uncertainty to an already challenging economic and dynamic political environment that grantee states will face in the years ahead as they work to maximize enrollment for children eligible in public health insurance programs. At the same time, what is being learned through *Maximizing Enrollment for Kids* will help inform implementation of reform efforts to enroll and retain current and newly eligible children and adults in coverage.

Methodology

This diagnostic assessment conducted as the first phase of *Maximizing Enrollment for Kids* was the first assessment of its kind to catalog strengths/challenges and opportunities across states in enrollment and retention systems. The assessment, which began in early 2009, required grantee states to complete a structured questionnaire, map their enrollment and renewal processes, participate in a site visit, and supply documents and data for review by Health Management Associates (HMA), which conducted the assessment in partnership with the National Academy of State Health Policy (NASHP). The team assessed the strengths, challenges and potential opportunities associated with each participating state's enrollment and retention systems, policies and procedures and external environment.

The diagnostic assessment centered on six areas:

- Enrollment and Renewal Simplification and Retention Policies
- Coordination between Medicaid and CHIP Programs and Among State Agencies
- Analytic Capacity for Program Management and Decision-making
- Client-centered Organizational Culture
- Non-governmental Partnerships and Outreach
- State Leadership

In March 2009, information was collected from each state in advance of onsite interviews. Each state provided annual or progress reports on Medicaid and CHIP; trend data on program enrollment and disenrollment, and the number of uninsured children; policy and procedure manuals related to enrollment and renewal; process maps for enrollment and renewal; interagency agreements that would affect enrollment and renewal, such as with a sister agency that conducts intake interviews; and contracts with third-party vendors who handle enrollment, retention, or a call center.

Each state was then asked to fill out a 20-page questionnaire that requested program leadership to describe key components of its enrollment and renewal practices and outcomes. The questionnaire addressed the six themes identified above, drawing on a recent review of the literature[3] and the expertise and experience of NASHP and HMA.

Based on the findings from the pre-site visit materials and questionnaire, an interview guide was developed to be used during a two day site visit in each state. During each site visit, interviews included state program staff and key state leaders and stakeholders outside the program whose views could help identify current strengths of the program and opportunities to cover more children. The type of people interviewed included: the Governor's health policy director, state legislators or staff of the legislative health care committees, policy advocates, organizations that work directly with families in completing applications, officials from sister agencies or bureaus, such as public health, and health plans involved in enrollment and retention.

Key findings were identified from information collected from each state to distill the strengths, challenges, and opportunities for grantee states to improve enrollment and retention of children in coverage. While many opportunities exist, this report highlights those believed to have the greatest potential impact on children's coverage while also being administratively and politically feasible.

[3] Wachino and Weiss. 2009.

Theme 1: Process Improvement and Paperwork Reduction

All eight states included in the diagnostic assessment have taken substantial steps to improve processes for families in applying for and renewing children's health coverage. While approaches vary based on unique program features and system constraints, a central theme is reducing paperwork in two key ways: reducing documentation requirements for families and using electronic means to streamline the physical submission, transfer and filing of paper documents. States have shown that taking steps to make the enrollment and renewal experience easier and more convenient for families can also lower administrative costs by introducing efficiencies that ripple throughout the eligibility system.

This section describes strengths, challenges, and opportunities related to improving the application, enrollment, and renewal processes.

Process improvements and paperwork reduction make enrollment and renewal simpler for families and more efficient for the state.

Enrollment Strengths

Like many other states, those participating in *Maximizing Enrollment for Kids* have adopted a number of strategies to simplify enrollment to make applying easier and more convenient for working families, families with limited English proficiency and families eligible for multiple state and federal programs. These efforts typically begin with simplifying the application and may include simpler eligibility rules. These efficiencies can pave the way for further reductions in documentation and paperwork through electronic data exchanges and other electronically-based tools. For example, several grantee states are increasing their reliance on third-party electronic data sources for needed documentation rather than waiting for families to provide it. Program officials find that these efforts can save time, improve accuracy, and further streamline the eligibility determination process.

Reducing Documentation and Paperwork Barriers

Grantee states have made completing applications easier for families and determining eligibility more efficient for program staff by reducing documentation and paperwork barriers. Methods utilized by these eight states follow.

- **Self-declaration of income**. Self-declaration of income shifts the burden of verifying income eligibility from families to the Medicaid/CHIP agency without threatening program integrity by relying instead on other data sources to document income. Eliminating the need for families to prove income eligibility for their children reduces one of the greatest barriers to enrollment. This strategy usually is paired with other income reporting simplifications such as elimination of an asset test. Alabama's CHIP program has incorporated this strategy into their enrollment processes, as has Wisconsin's Express Enrollment (presumptive eligibility) program.
- **Third-party data.** Several states are using third-party databases as a means to identify potentially uninsured children (through file matching) or to verify enrollment data. Some states have the capacity to identify eligible children using database matching and information obtained from other public agencies such as the food stamp program (now called the Supplemental Nutrition Assistance Program, or SNAP). Government databases and commercial third-party employer-payroll data bases are used in Louisiana and Virginia to verify

employment information. In Wisconsin, the state has developed and maintains an employer health insurance data base to which firms are required to send requested information.

- **Vital records check for citizenship verification.** Many states have been successful in gaining electronic or manual access to vital records to address the Deficit Reduction Act of 2005, requirements for proof of identity and citizenship to qualify for Medicaid. Checking vital records for citizenship verification on behalf of applicant children is another specific application of using third-party data that shifts the burden of proof from families to the agency. Nearly all states participating in *Maximizing Enrollment for Kids*, except the Alabama Medicaid program, have adopted this practice. Under new CHIPRA rules, Virginia allows parents one year to produce documentation. Beginning in 2010, states have the option of using the federal Social Security information system to confirm citizenship.
- **Electronic signature**. A number of states have pursued the opportunity provided by CMS' approval of electronic signatures in lieu of hand-signed paper documentation to submit a web-based application, including Alabama, Louisiana, Utah and Wisconsin. Allowing electronic signatures for online applications eliminates the need for families to print, sign and mail a signature page, and thus reduces paperwork for families and program staff.
- **Electronic case records**. Converting from paper to electronic case records can promote greater efficiencies and increase enrollment by lowering the documentation burden on families. States such as Louisiana, Utah and Wisconsin have found that electronic case records and scanning capabilities, while requiring a sizable financial and staff training commitment up front, can produce lasting efficiencies in improving staff productivity by: enabling a redistribution of workload within and across offices; facilitating outreach and enrollment efforts off-site (with program staff or community-based application assisters) through access to real-time data; reducing duplication of effort and eliminating paper filing, searching and retrieving tasks.

Expanding Opportunities to Apply for Coverage

Through policy, interagency coordination, and technological advances, the eight grantee states have made tremendous progress in expanding opportunities for families to apply by making applications available where families already are—including their home, another social service agency, a medical setting, a community event or some other public place. States also generally have maintained traditional avenues for appl ying, such as calling and requesting an application to be mailed or completing an application at a local agency.

- **No wrong door policy.** States with separate CHIP programs or multiple agencies involved with Medicaid or CHIP enrollment have improved coordination through a "no wrong door" policy, which means families can visit agency offices, mail or otherwise apply for either program, with assurances that children will be enrolled in the program for which they are eligible. The programs, rather than families make this determination. Electronic case transfer capabilities enhance the effectiveness of this policy. Virginia adopted a no wrong door policy for its Medicaid and CHIP programs as part of a package of simplification efforts that also included a joint application.
- **Joint application.** Complementing a no wrong door policy is a joint application for Medicaid and CHIP, which all eight *Maximizing Enrollment for Kids* states have implemented, regardless

of their program structures. Some states, including Illinois, Massachusetts, Utah and Wisconsin, have extended the joint application concept to other health or social service programs such as SNAP or WIC, so that families may apply for multiple programs with one rather than separate applications.

In Wisconsin, where SNAP and Medicaid/CHIP programs are both administered by the Department of Health Services, the agency has created an online application that helps families assess and apply for all the programs for which a family member may be eligible. Massachusetts has an electronic application system that will determine eligibility for several health and social support programs through one online application.

A challenge to this approach in all states is balancing the desire to keep the application short while also helping families apply—just once—for additional benefits to which they may be entitled. In New York and Utah, applicants may choose to complete a simpler application just for health coverage, or a more extensive application to determine eligibility for multiple programs.

- **Online applications.** Applying online is rapidly becoming the enrollment method of choice for many families. All but one grantee state (New York, which plans to use its *Maximizing Enrollment for Kids* grant funding, in part, to support adding this feature) has a web-based application. In Massachusetts and Wisconsin, the online application is part of a web-portal with links to eligibility information, application tools, and account management features. Applicants can save and retrieve their application if unfinished, and check its status. Louisiana is planning to add account management features to its online application. These states have also enabled community partners to assist applicants with the online application (see Theme 4). The full potential of online applications to improve enrollment success rates is somewhat limited when clients must still submit paper-based documents in order to complete their application, and when the online application is difficult for families to complete accurately on their own (without access to application assisters), as is the case in some grantee states.
- **Computer kiosks.** Alabama has begun experimenting with computer kiosks that enable families to initiate enrollment in a health setting, such as an emergency room, or some other public place (e.g., library, post office). Called Audio Visual Application Assistor (AVAA), this new computer software program that Alabama is piloting in four public health clinics talks applicants through the application process in Spanish or English. The potential usefulness and efficiency of a computer kiosk as a paperless enrollment tool is greatly enhanced if paired with self-declaration of income and third-party data matching, as well as personal assistance with the process. Louisiana is considering opportunities to pilot kiosks in hospital, library or other community settings that would allow applicants to enroll or check eligibility and allow members to report changes.
- **Presumptive eligibility for children.** Presumptive eligibility allows a "qualified" entity (e.g., federally qualified health clinic, physician, Head Start, WIC, child support enforcement agency) to grant a child temporary public coverage based on the family's declaration of income so that a child can obtain medical care while the application is processed for a formal determination of eligibility. Illinois, Louisiana, Massachusetts, New York and Wisconsin have each adopted some form of presumptive eligibility for children. These states have generally found that presumptive eligibility is a better tool to promote enrollment when the burden on families to follow through on completing the application process is minimized.

- **Outreach, enrollment, and renewal assistance:** Nearly all grantee states have provided grants or incentive payments to support community-based organizations and other stakeholders' assistance with the application process. A more detailed discussion of these initiatives is provided below in Section 4: Consumer, Community and Stakeholder Engagement.

Simplified Enrollment and Eligibility Rules

- **Accessibility of applications.** Central to states' efforts to make enrollment easier for families is simplifying the language to accommodate families with low literacy or limited English proficiency. As applications have become shorter and simpler, their availability in languages other than English has also expanded to facilitate enrollment of children of immigrants. Online applications in Alabama, Illinois, Massachusetts, Utah, Virginia, and Wisconsin are also available in Spanish. Virginia also has a Spanish-language version of its website and an informational flyer about their FAMIS program is available in English, Spanish and other languages and can be downloaded and printed from the website. In Alabama, Illinois and Louisiana, and in other grantee states, application assistance in languages other than English is available by telephone.
- **Consolidated eligibility rules.** Categorical eligibility changes (e.g., when a child's eligibility changes because she ages out of an eligibility group and income eligibility levels drop for the older group) can be very confusing for families. In states with a separate CHIP program, children in the same family may qualify for different programs because of age differences, with one child eligible for Medicaid and another eligible for CHIP. These eligibility differences can affect which providers children can see, lead to inadvertent coverage losses, and otherwise disrupt their continuity of care. Most grantee states have taken some steps to consolidate or align eligibility rules to minimize these types of disruptions and maintain eligibility within families. Massachusetts New York, Virginia, and Wisconsin have passed initiatives to either reduce or consolidate eligibility categories recently, or align income eligibility across age groups.
- **Reduction in CHIP premium payment barriers.** Requiring low-income families to pay premiums toward coverage often presents a financial barrier and practical inconvenience in submitting payment. Virginia eliminated premiums altogether, finding that administrative costs exceeded payments. Louisiana charges a premium starting at a relatively high income level (above 200 percent FPL). Nearly all grantee states that charge a premium in CHIP have expanded the mechanisms for payment to include automatic debits from a checking account (i.e., electronic funds transfer) or credit card payment. Alabama allows families a year to pay an annual premium.

Renewal Strengths

The eight grantee states have made considerable progress in simplifying enrollment and renewal processes over the last decade, and continue to strive toward maximizing enrollment, even in difficult economic times. Grantee states have been successful in improving their retention rates for children in Medicaid/CHIP by adopting policies and procedures that include lengthening the time between renewals, guaranteeing eligibility for one year, and taking on greater responsibility for verifying

required information when cases come up for eligibility review. The latter typically involves relying on greater levels of automation and electronic data exchange. For example, in Louisiana, a remarkable 95 percent of children's Medicaid and 90 percent of CHIP renewals are completed without the family needing to submit paperwork. Policy options range from requiring an eligibility review no more than once per year to applying an administrative renewal process that requires no effort from families for their children's coverage to continue.

- **Annual renewal.** The Center for Medicare and Medicaid Services (CMS) requires a review of continued program eligibility at least annually. One of the simplest ways to improve retention and decrease staff workload is to review eligibility no more than annually. All grantee states except Utah's Medicaid program have adopted this policy. With annual renewal, families must still report income changes during the year that might make a child ineligible; in practice, the policy is difficult to enforce, but families carry the burden of being at financial risk for not reporting the change.
- **12- Month continuous eligibility.** Continuous eligibility allows coverage up to 12 months, the maximum time permitted under federal law, regardless of income changes. This policy, one recently promoted in CHIPRA legislation, is particularly helpful to children of families with seasonal or other types of workers who experience occasional income fluctuations. More than half of the grantee states—Alabama, Illinois, Louisiana, New York, and Utah (for CHIP)—have adopted this policy.
- **Pre-populated renewal form.** Sending renewal notices that already contain known client eligibility information is one way to make the renewal process easier for families to complete. Families need only update information that has changed since the last review. This strategy can simplify the renewal process for families who receive and respond timely to the notice. However, it is unlikely to improve parental compliance with renewal requirements for families who do not receive the notice, do not open it or cannot understand it, which were common reasons cited among program officials in grantee states as to why families do not complete the renewal process. Programs in six of the eight grantee states (excluding Louisiana and Wisconsin) have implemented pre-populated renewal forms.
- **Ex parte renewal.** Ex parte renewal processes give eligibility staff access to external information systems, such as Food Stamps, state tax information, other government databases, or commercial systems to verify family income for a child's eligibility review. If the ex parte process can verify income, the child is renewed without further involvement of the family. If the data match does not confirm eligibility, families are given the opportunity to provide additional information to demonstrate eligibility. Louisiana, the only grantee state to use ex parte renewal, renews one-third of children through this process.
- **Administrative renewal.** Administrative renewal is a term applied to other forms of simplified renewal using third-party data matching. The children eligible for administrative renewal are selected based on a high probability of eligibility for continued enrollment, such as being stably low-income or disabled. For example, Louisiana sends a notice to families who appear to be eligible asking them to report any changes in income or household composition. (see Text Box for more details.)

  Illinois uses administrative renewal for children with incomes below 200 percent FPL. The state sends a letter to families due to renew, which includes pre-populated income information

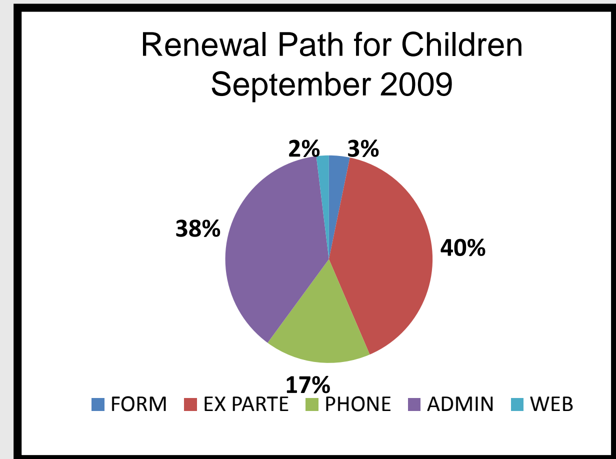
based on third-party data matching. If the information is correct, and it indicates the child is still eligible, the family does nothing. Families are expected to submit any corrected information.

- **Telephone or online renewal.** Telephone-based and internet-based renewals are potentially paperless approaches that some states promote as an alternative to mail-in renewals or as a fall back to ex parte or administrative renewal. When a process improvement study in Louisiana showed that eligibility staff was spending as much time on the telephone with applicants through mail renewal as with a telephone renewal process, they eliminated mailed renewal notices; a signature is not required to complete the renewal process. States with online applications are just beginning to roll out online renewal tools (including Alabama, Louisiana, Massachusetts and Virginia) that may be complemented with file attachment capabilities or account management features to reduce the likelihood that the client will need to take additional steps to mail paper documents to the agency.
- **Off-cycle renewal.** This renewal approach uses client contacts with the agency (or sometimes with a provider) as an opportunity to update case information and renew coverage for an additional eligibility cycle. Louisiana has adopted this approach, which relies on eligibility staff's access to an electronic case record. Illinois will update insurance whenever a child's SNAP benefits are recertified. Each All Kids renewal resulting from a SNAP recertification resets the 12-month clock for a child's continuous eligibility in All Kids. Alabama has implemented a similar process.

Louisiana's Renewal Process

Louisiana's renewal process is a national model for client-centered renewal. Most cases can be handled with minimal burden on the families and without sacrificing integrity of the process. Louisiana's Medicaid Payment Error Rate Measurement (PERM) rate is 1.54 percent, which is 25 percent of the national average. The following four renewal approaches account for 95 percent of Medicaid and 90 percent of LaCHIP renewals:

- Ex parte renewal, which involves verification of information using Food Stamp case information, state tax information or a private employment and income verification service (33 percent of Medicaid and 33 percent of LaCHIP);
- Administrative renewal, which involves notices to families meeting certain criteria (see below), requesting that they report changes in income or household composition (44 percent of Medicaid and 4 percent of LaCHIP);
- Telephone renewal, which involves an incoming or outbound call in which factors subject to change are reviewed (15 percent of Medicaid and 37 percent of LaCHIP); and
- Web-based renewal, which represents 4 percent of LaCHIP cases.



Source: Ruth Kennedy, presentation to the Alliance for Health Reform, December 2009.

The Louisiana Department of Health and Hospitals has developed criteria to determine which cases are appropriate for ex parte renewal or administrative renewal. Decision criteria are programmed into the eligibility information systems, called MEDS, and ex parte or administrative renewals are used whenever possible.

Specific cases are eligible for administrative renewals if they meet certain eligibility criteria such as cases where: the applicant is a relative other than the parent (e.g., grandparent, aunt, uncle); the parent has Retirement, Survivors Disability Insurance (RSDI) income; a single parent has stable unearned income, such as child support or alimony; and/or there has been no change in eligibility in the last three years and net income is less than or equal to $500.

If a child's case does not qualify for administrative renewal, and he or she has an open Food Stamps (now called SNAP) case in the Food Stamps (FS) eligibility system, the case is eligible for ex parte renewal. On a monthly basis, all children's health insurance files that are due for renewal are matched against the FS eligibility system maintained by the Department of Social Services.

If the information in the FS system cannot be used to determine eligibility because the FS case is closed or the FS information is out of date, a case is considered for renewal involving contact. If changes are reported, the case reverts to a regular renewal process. Otherwise, the eligibility is extended and the electronic case record is annotated to show completion of renewal without ever having been handled by an eligibility worker. Only 5 percent of Medicaid and 10 percent of LaCHIP case reviews require the member to submit a signed renewal form in order to renew their eligibility.

Challenges

While grantee states have made abundant progress simplifying enrollment, progress simplifying renewal, generally, has not kept pace. The primary reason eligible children lose coverage is because the family failed to respond on time or accurately to renewal notices. In some grantee states, as many as 40 percent of children do not complete the renewal process. Some acquired other coverage or lost eligibility (the data are often insufficient to know for certain), although many are known by program staff to have lost coverage for administrative reasons only. In some states that are able to track this information, the percentage of children churning in Medicaid or CHIP—that is, reapplying within 60 to 90 days of losing coverage—exceeds 25 percent of all closures. Churning is costly to families when it prevents children from receiving needed care due to a loss of coverage, and costly to state programs in administrative resources spent to reenroll children and reestablish their medical home.

The most challenging problems grantee states face in improving their processes and reducing paperwork appear to be system and structural constraints that may require both a vision of the paperless program office and long-term investment toward achieving that vision. At the same time, grantee states are finding limitations to technology that highlight a need to continue their investments in human resources.

- **System constraints.** A variety of practical challenges may impede simplified enrollment and renewal, particularly involving the use of third-party data matching. Some of these challenges relate to linking client data, particularly in states with older, "legacy" eligibility systems running on computer mainframes that have limited automation and electronic exchange capabilities. These older systems, typically operating in social service agencies and separate Medicaid programs, often require continued reliance on paper-based information exchange.
- **Structural constraints.** Complex organizational structures that require significant coordination among multiple agencies to share and exchange data in order to facilitate automated eligibility determination is another common challenge. Examples include separate Medicaid and CHIP programs administered in different state agencies with varying resource constraints, and Medicaid and social service programs with different priorities and organizational cultures. (Discussed further under Section 3: Leadership and, Agency Capacity, Coordination and Culture.) Both system and structural constraints often contribute to a continued reliance on paper-based information exchange between or among programs.

  Related is the challenge of balancing the desire to keep the application brief while also assessing a child's or family's eligibility for additional benefits. Finally, many states have high worker caseloads, limiting their opportunities to step back and take stock of inefficiencies and potential opportunities.
- **Limitations of technological innovations.** Technological tools alone, such as online application and renewal, telephonic assistance and computer-aided enrollment kiosks, will never fully replace the need for the "human touch." There will always be families who struggle with literacy or language, or the complexities of their daily lives. They will continue to challenge programs to find and successfully enroll them, and to keep their contact information current. Finding the right balance between levels of automation and electronic communication with human resources—within the program and in communities across the state—is an ongoing effort.

Opportunities

The diagnostic assessment of the eight grantee states revealed a number of steps that program leaders can consider to improve their enrollment and renewal processes toward the ultimate goal of enrolling and retaining eligible children in Medicaid and CHIP. Most of the opportunities involve analyzing data to answer key questions that can guide states in setting priorities and making informed decisions suitable to their unique circumstances. Helpful to this process is pursuing strategies centered on a philosophy of getting and keeping eligible children on the program rather than making it easier for families to comply with program rules and requirements.

- **Use enrollment and renewal process maps to identify barriers and opportunities.** As part of the diagnostic assessment, each state participating in *Maximizing Enrollment for Kids* developed process maps of enrollment and renewal steps to better understand the role of families, workers and information systems in the flow (and bottlenecks) of information and decision-making. Process maps are helpful tools for identifying duplicative steps and delays, and for documenting what steps are manual or automated and dependent on a family's compliance. Grantee states can use these tools to identify very specific opportunities for process improvement, including eliminating documentation or automating its retrieval through other sources. As Louisiana has successfully demonstrated, program leadership can then follow process improvement techniques (e.g., "Plan, Study, Do, Act" cycles) for testing small modifications to current processes, which can yield valuable information, with limited risk and resources, before making a full commitment to implement a procedural change.
- **Estimate system costs.** There are likely opportunities for grantee states to simplify or eliminate documentation requirements that are the family's responsibility, particularly through greater reliance on third-party data sources. A promising strategy is to estimate costs associated with income documentation and verification processes in the current system. This information can be used to help determine whether a business case can be made for gaining access to third-party data systems to replace the activities—and costs—for some portion (but not 100 percent) of renewals. Results from Louisiana, Illinois and other states not participating in *Maximizing Enrollment for Kids* could be instructive. Additionally, by examining enrollees' income over time, other grantee states may be able to make a case for implementing administrative renewals for families meeting criteria highly associated with stable eligibility—and thus maintain a high eligibility accuracy rate.
- **Virginia estimated system costs of charging premiums in CHIP**. Based on results of its assessment that premiums were not cost-effective, the state eliminated them. Other grantee states that charge premiums for participation in CHIP may find it useful to replicate this analysis.
- **Seek input from stakeholders.** Gathering information directly from eligibility workers, families, community outreach groups and providers can also provide insights into barriers associated with the application, as well as identify opportunities for assessing the potential of presumptive eligibility, off-cycle renewal and other strategies that could make enrollment or renewal more convenient or efficient. Involving stakeholders in process improvement efforts helps ensure effective implementation and acceptance of program changes.

  Alabama, Virginia and Wisconsin have been particularly effective in partnering with local foundations, universities or community partners to conduct surveys, focus groups and interviews with client families in the process of testing and introducing new enrollment or

renewal procedures. Louisiana created a management position dedicated to quality improvement to facilitate communication about program improvement ideas from eligibility workers to supervisors and managers.

- **Invest in system improvements.** Grantee states can gain productivity efficiencies and long-term savings from information technologies that automate data-sharing between agencies and reduce the burden on families to provide information that can be obtained through third parties. Program leaders who expressed interest in electronic case records, scanning capabilities, "middleware" solutions to integrate legacy systems with web-based applications or other technological improvements have numerous examples within this eight-state group and outside it to learn more about the planning, implementation, costs and training issues associated with each.
- **Focus special attention on retention strategies.** With the possible exception of Louisiana, all grantee states can do more to improve their renewal or eligibility review processes to lessen the burden for families to maintain coverage for eligible children. Adopting strategies and procedures that improve retention helps families avoid additional time and effort to reapply when their children lose coverage at renewal but are still eligible and reduces administrative costs. Additionally, aiming for high retention rates is also an effective quality strategy for improving continuity of care for poor and low-income children, many of whom are living with chronic conditions. Making the retention-quality of care connection for legislators and community stakeholders may be a helpful way to promote investment in system improvements to enrollment and renewal processes.

Theme 2: Data Analysis and Integration

The eight states participating in the *Maximizing Enrollment for Kids* program seek to better understand how to capture and use data to improve their management decision-making and assess the effects of their policy decisions. A lack of sufficient data and analytic capacity to guide program decision-making is a major challenge for children's health insurance programs. In some states, competing priorities, driven by budget or political constraints, or other factors, have prevented data reporting and analysis from rising to the top of the agenda for program goal-setting. In other states, systems challenges have significantly impeded progress. In a few states, however, programs are making good progress toward generating information to guide program policy and operations.

> *Data analysis and integration of information systems helps states design and monitor their process improvement strategies for streamlining documentation requirements, finding eligible but uninsured children, and, ultimately, expanding coverage for eligible children.*

Strengths

Key to using information to improve enrollment and retention rates is having some level of infrastructure to support data integration across programs and ongoing collection, analysis, and reporting of performance metrics that can monitor enrollment and produce trend analyses. Analytical tools and measures that can enumerate and characterize the state's uninsured children, identify and quantify at what point and why applications or renewals are denied or rejected, and that can produce accurate churning rates are examples of ways states are improving or seek to improve their analytic capacity.

- **Infrastructure for data analysis.** Having an internal capacity for program data collection and analysis or having external capacity through relationships with a university or local foundation helps ensure that the program's analytical capacity can be permanently integrated into program management and decision-making rather than being ad hoc.

  Several grantee states use a mix of internal and external resources to support data analysis for decision-making. New York plans to create a new Enrollment Center that will centralize information about renewals, making it possible to track children's continuity of coverage longitudinally. Virginia works closely with a state foundation and a statewide advisory group to support data collection and analysis of uninsured children and program performance. In Alabama, the CHIP data unit, directed by an epidemiologist, provides an infrastructure for conducting analyses related to coverage, access and health outcomes. In Louisiana, in-house analysts generate standardized enrollment and renewal outcomes at the regional, local and sometimes individual level that are shared with local offices throughout the state.

- **Actionable performance measures.** Illinois and Louisiana have developed specific measures to assess and report the percentage of application denials or disenrolled cases that are due to a procedural outcome, such as abandonment, or failure to respond, versus lack of eligibility for the program. Louisiana measures procedural denials and closures because they are outcomes that program leadership can directly influence through its policies and procedures. Beginning with a process improvement collaborative supported by the Robert Wood Johnson Foundation's *Covering Kids & Families* program, Louisiana has built an internal infrastructure for measurement and reporting throughout the LaCHIP program that includes a process improvement coordinator position.

- **Use of a single identifier across programs.** A common client identifier is essential to identifying children enrolled in other programs who may be eligible for Medicaid or CHIP, by virtue of their eligibility in another program, or through the information available to determine eligibility. A single identifier can also help states integrate data across programs to analyze health and social outcomes against spending on health and social services. Alabama, Illinois Massachusetts, Utah, and Wisconsin have a single client identifier across multiple programs.
- **Single or compatible information systems across sites.** Similar to a single identifier, having a single information system or building electronic interfaces to facilitate data exchange across programs or agencies can support states' efforts to identify children known to other programs who may be eligible for Medicaid or CHIP. For example, Wisconsin has a single eligibility information system for FoodShare (its SNAP program) and BadgerCare Plus, its Medicaid/CHIP program. Illinois has a single eligibility system for All Kids (its Medicaid and CHIP program), TANF, and Food Stamps (SNAP). Louisiana implemented a Medicaid eligibility system capable of matching client information from the SNAP eligibility system. Utah has had a single information system (PACMIS) for multiple programs including Medicaid, CHIP, Food Stamps (SNAP), TANF, Child Care, and others since 1988.
- **Electronic case records.** As described in Section 1: Process Improvement and Paperwork Reduction, an electronic case record offers multiple opportunities to improve staff productivity and facilitate simplification efforts. It also can be a powerful and efficient tool for data collection and analysis when skilled staff or external resources are available to collate, interpret and report standardized information on a regular basis that can be used to answer key enrollment and renewal questions, and monitor progress over time.

Challenges

States face a number of barriers or constraints to obtaining and using information to analyze patterns and trends that can help them monitor enrollment and retention. Limited expertise or staff resources and incompatible information systems across agencies, including Medicaid "legacy" systems, often contribute to states' challenges to utilize data effectively for decision-making. We observed relatively greater levels of complexity associated with data collection and analysis that involve data exchanges across programs with separate reporting structures or separate eligibility information systems. Some of the most challenging problems we observed included:

- **Lack of a single identifier.** Without a single, unique client identifier, it is difficult to track children across programs, or identify potentially eligible children from other agency programs, such as SNAP or WIC.
- **Multiple, disconnected information systems.** Multiple information systems are particularly challenging in states with Medicaid and separate CHIP programs that are administered by different agencies and have different systems that determine program eligibility. This often requires significant collaboration and resources to facilitate an exchange of data across information systems to facilitate coordination of applications and renewals from the different programs.
- **Legacy Systems.** Medicaid legacy information systems present multiple challenges to data analysis and integration. For IT staff, making program changes to extract data is complex and

time consuming. Significant financial and technical resources may be required to retrofit or replace these systems.

- **Lack of standard or actionable measures.** Most grantee states lack reliable data about reasons for disenrollment. A lack of standardized measures across programs or local agencies limits the ability of most grantee states from being able to accurately analyze application denial or termination codes. In some cases the measures are too vague to inform or guide enrollment and renewal process improvements as well.
- **Competing priorities for IT staff time**. Particularly when information systems changes involve IT staff from multiple agencies, or a statewide rather than program-dedicated agency, limited availability and competing priorities of IT staff can be a significant barrier to making processes more automated and for improving establishing or improving data exchanges across information systems maintained by multiple agencies.
- **Lack of refined characteristics of uninsured children.** A lack of specific information about the demographic and other characteristics of uninsured children limits states' ability to target outreach efforts, particularly when coverage rates are high but pockets of uninsured children remain and are hard to identify and reach. Although national surveys that collect data on the uninsured are often too imprecise to provide meaningful information beyond a state level, the recently released American Community Survey may offer new promise as a more meaningful national data source. Medicaid and CHIP agencies often do not have the resources to conduct their own surveys to collect information on the uninsured and must depend on other agencies or agreements with universities or foundations to support this effort. A lack of resources to conduct oversampling in order to develop more precise estimates of uninsured children often presents an additional barrier.

Opportunities

Despite considerable challenges, states can take a number of incremental steps to improve their data analysis capabilities, with the ultimate goal of making more informed management, operations and policy decisions. Common to each approach described below is the suggested involvement of external partners, explored further in Section Four: Consumer, Community Partner, and Stakeholder Engagement. Possible incremental steps include:

- **Set an analytic agenda and create measures to support it.** Agreement on priorities and an analytic agenda are key steps to describing and communicating a program's information needs. Once internal concerns and priorities are explored and established with program staff and state or program information technology specialists, it may be helpful to create partnerships with advocates, providers, academic institutions, local, regional or national foundations to respond to the agenda and provide additional input as well as support for achieving program goals.
- **Target children known to the system for outreach.** Collecting data on recently disenrolled children, and analyzing that data for patterns of characteristics is a simple example of how system data can be used to generate information to guide development of a targeted outreach strategy. Community partners can be helpful in validating the results and implementing the strategy.

- **Collect, analyze and report existing data for key audiences.** Whether through existing staff resources, or in collaboration with university or foundation partners, program officials can use existing data on uninsured children, coverage rates and churning to educate key stakeholders on the need and value of good data systems to improve productivity, and reduce per client enrollment and renewal costs. Having a state's legislative body or executive office authorize creation of a statewide coalition dedicated to children's health issues is another way to build an external infrastructure for supporting program improvements based on data analysis and public education.
- **Seek support for cross-agency initiatives.** Because almost all states need cooperation and coordination from other agencies to maximize opportunities to identify and enroll eligible children in Medicaid and CHIP, it can be helpful to seek leadership and resources from states' administrations or legislatures to support new cross-agency initiatives. A focus on shared goals, such as improving children's opportunities for success through health and education can build cooperation among agencies with key missions other than health care access.
- **Seek opportunities for federal CHIPRA, ARRA/HITECH funds.** Possibly with help from strategic partners (NASHP, advisory boards, foundations, university research programs), states may be able to leverage their resources by matching their program gaps and priorities with federal spending opportunities.

Theme 3: Leadership and Agency Capacity, Coordination, and Culture

Aligning policies and programs in support of enrollment and retention and promoting a culture of coverage is a responsibility shared among several levels of state government. Policy leaders, including the governor, legislature, and agency heads in grantee states have demonstrated their commitment to children's coverage by making it a priority, allocating resources, and promoting inter-agency cooperation. Program leaders work within and across Medicaid and CHIP programs to align policies and processes, and to minimize program complexity for families. States are working to provide training for enrollment workers to promote practices that make it easier for eligible children to enroll in and retain coverage. Attention is being given to opportunities for non-health agencies to contribute to the state's coverage agenda.

Relationships between Medicaid, CHIP, and other agencies vary tremendously by state, but are growing in importance relative to achieving enrollment goals. Many states have roles for sister agencies or local governments in enrollment and renewal (often integrated with other social service functions), making process alignment and customer-service important management priorities. States that have brokered data sharing arrangements have seen an impact on coverage rates.

States have taken advantage of flexibility in federal statute to structure their CHIP programs in many different ways, leading to a wide range of agencies that collaborate on children's coverage. Some states have created a single children's coverage program. Examples among grantee states include Illinois' All Kids, Louisiana's LaCHIP, Massachusetts' MassHealth; and Wisconsin's BadgerCare Plus. Utah created a separate CHIP program, and Virginia both expanded Medicaid to a higher income level and added a separate program for higher income children. About half of grantee states set policy for their children's coverage programs in a single agency, and the remainder involve two or more agencies or separate offices within an agency. It is also common for Medicaid and CHIP programs to involve a separate agency in eligibility determinations and renewal, either centrally or in local offices.

Strengths

All states participating in the *Maximizing Enrollment for Kids* Program demonstrated positive effects of leadership, capacity, agency coordination, and culture on children's coverage. While approaches vary based on unique program features and system constraints, each has a visible commitment from its top leadership and has aligned policies, procedures, and messages to some extent to make it easier to enroll and retain eligible children. Some of the characteristics and strategies that appear to be most influential include:

State and local agency collaboration facilitates enrollment and retention of eligible children. A client-centered organizational cultural promotes coverage and productivity.

- **High-level commitment.** Despite the challenging economic environment facing all states, top leadership's commitment to children's coverage had not diminished in any of the eight grantee states as of early summer, 2009. Interviewees including Governor's staff, legislators, legislative staff, agency heads, mid-level managers, and front-line eligibility workers were clear on their state's commitment to identifying, enrolling, and retaining eligible children in Medicaid and CHIP.

Interviewees in each state cited successful coverage expansions and program simplifications over the past 24 months that were helping them to achieve their goals. Policy leaders' recognition of the importance of coverage and their willingness to commit time and resources was universal. For example, the Utah legislature voted to no longer close CHIP to new enrollees; New York expanded CHIP to 400 percent FPL and aligned child and parent Medicaid income levels, and eliminated the face-to-face interview (both effective in 2010); and Massachusetts was marketing universal family coverage, which has attracted previously eligible but uninsured children of parents who can now buy insurance. Wisconsin's Governor set a goal that at least 98 percent of the state's population has access to affordable health insurance, and in 2008, expanded BadgerCare Plus to cover all uninsured children, regardless of income. In 2009, the Alabama legislature appropriated funds to expand eligibility for ALL Kids (CHIP) from 200 to 300 percent FPL, effective October 2009.

- **Maintenance of resources**. Despite very dire budget circumstances, these leading states maintained their commitment to children's coverage. None reduced children's eligibility or benefits. Where cuts in health insurance programs were unavoidable, they affected provider rates, outreach support, and adult eligibility, all of which can affect children's coverage in the long term, but avoid drastic changes to children's programs in the short run.
- **Simple organizational structures help with policy alignment.** States that created a single coverage program for children have relatively few coordination problems and believe that families also find it easy to understand children's coverage in their state. This is not to say that integrating Medicaid and CHIP rules does not take work; however, relative to states with separate agencies and funding streams, a lower level of effort was observed.

  States with separate Medicaid and CHIP programs which integrate staff and processes in one department or agency also reported relative ease in coordinating policy and resources. States that have entirely separate staffs for Medicaid and CHIP reported good coordination—as they worked to deliberately align the policies of the two programs. Overall, separate programs require more communication among program leaders to compare strategies, discuss possible changes, review data, and consider ways to coordinate resources.
- **Technology that supports coordination.** As discussed in the prior section, coordination in some states is made easier because all children are tracked in a single data system, or because the systems use a single child identifier which greatly simplifies the transfer of cases and data exchange.
- **Processes for transferring applicant information**. Some states have created processes for transferring applications, documentation, or verbal information provided by applicants between offices, allowing families to submit information to the location most convenient for them. Some states have passed a "No wrong-door policy" which mandates this simpler process; others do it without the policy. Virginia increased Medicaid enrollment 43 percent when it adopted its no wrong door policy. (Howell, 2006) Alabama's CHIP devotes specific staff to handle transfer cases in order to prevent cases bouncing back and forth between agencies.
- **Accountability and recognition**. Several states promote effective eligibility and renewal processes by training frontline workers to be customer-focused, by recognizing workers who reflect the agency's philosophy, and by acknowledging offices with high performance, through newsletters, office postings and ceremonies.

Louisiana's recognition program goes farthest in linking agency policy to staff performance. Louisiana's awards program, WorkSmart!, recognizes outstanding achievements in seven priority areas including reduced processing times, reduced numbers of procedural closings, and increased use of online application and renewal tools. Teams enter the awards competition by describing their aims, the processes they undertook, and their results. An evaluation committee assesses their success. Results in several areas have been dramatic and had a positive effect on children's coverage. For example, Louisiana's rate of closures due to procedural reasons dropped from 22 percent in 2001 to less than one percent in 2009, the result of multiple strategies but including this realignment of worker incentives.

- **A culture of continuous quality improvement.** All states gave numerous examples of how they are continuously improving their programs. Leadership, data, and external partners are the sources of many of their initiatives. Louisiana has added an additional strategy to its toolkit. Developed and refined over a 10 year period, LaCHIP staff applies management science principles to identify potential eligibility simplification processes and then conducts small-scale testing and rigorous analysis before adopting policies and disseminating practices that improve operational efficiencies while maintaining acceptable accuracy rates. Employees are encouraged to participate in the identification of areas in need of further improvement. All eligibility workers are state employees who report directly to the Department of Health and Hospitals, which has facilitated the agency's ability to hold workers accountable through management reporting of quality metrics, such as procedural denial and closure rates. Managers evaluate and reward staff based on performance measures that support its mission of enrolling and retaining all children eligible for LaCHIP.
- **Third-party data matching**. Several states have partnerships with sister agencies that allow them the ability to look up information that can be used to determine Medicaid and CHIP eligibility. In Virginia, local agencies have access to SNAP data and can renew Medicaid eligibility the same time they renew SNAP eligibility. Eligibility workers in Wisconsin have access to eight data sources that can replace the need for some families to document income, identity and citizenship. They can further look up whether or not a child has employer-sponsored coverage in a separate database. In 2004, Utah linked 18 separate databases in an online data brokering system called eFind. Eligibility workers are able to check social security, vital statistics, and numerous sources of income and asset data in lieu of requiring families to produce documentation. Utah is also launching a new eligibility system this year (eREP) to replace the outdated legacy system (PACMIS) that has linked Medicaid, CHIP, TANF, Food Stamps, and Child Care data for more than two decades. In Illinois, eligibility workers are able to look up Social Security and unemployment benefits and SNAP data is used to renew medical eligibility both at renewal and off-cycle. Alabama Medicaid has access to TANF, SNAP and child support information through data sharing, and implemented Express Lane eligibility for renewals effective 10/01/09.

Challenges

Most states faced issues of coordination which resulted from Medicaid/CHIP program differences that are accentuated by differences in information systems, staff organization, centralization of responsibilities, and availability of resources, to name a few. As the historical significance of many of these differences is diminished, structures have not evolved to reflect many states' views that

Medicaid and CHIP are meant to assure seamless coverage for children. Some of the greatest challenges noted during the interviews were:

- **Differing leadership attitudes toward Medicaid versus CHIP.** A few states noted that some state policy makers have favored CHIP over Medicaid in funding and staff resource decisions. Explanations for distinguishing between the two focused on philosophical differences between parties and long-term associations between Medicaid and welfare. In day-to-day operations, CHIP and Medicaid staffs work closely to coordinate and share resources to overcome these different levels of support. Medicaid and CHIP outreach, enrollment, and renewal are so interconnected that coordination is essential even if leadership differences exist.
- **Multiple agencies**. In some states, separate Medicaid and CHIP systems, cultures, and/or performance standards have reduced the effectiveness of policies to enroll and retain children in coverage. Adding in the additional complexity of coordinating with a separate enrollment agency or agencies can complicate families' experiences.
- **Lack of alignment.** Policies, procedures, and data systems that are not aligned among programs create enrollment and renewal barriers for families. For example, one state has a six month renewal for Medicaid and 12 months for CHIP, which can be confusing to families with a child in each. This happens as a result of having different income eligibility levels for younger and older children. The same state has an asset test for Medicaid, which means some children would be income eligible for Medicaid, but their assets put them into CHIP, where they need to pay a premium. At least one state transfers a case by printing a paper copy and sending it by courier to the other program.
- **Staffing constraints.** Although budget constraints have not led to children's eligibility or benefit cuts this year, most states reported staffing constraints. Staff size has not kept pace with enrollment growth in many states and in some cases, was reduced. In most states, staff has taken on larger case loads, leaving them less time for assisting families. Without being able to quantify the effect, staff shortages were noted by both state officials and advocates. As one advocate said, "Clients don't feel valued when voice messages are not returned, forms are lost, and waiting times are long."
- **Local variation.** Several participating states contract with local offices of state agencies or local agencies to determine eligibility for coverage. States are using staff training, messaging, and incentives to create uniform processes across local sites, but differences still occur. They are sometimes attributed to differences in management style, competing interests (such as saving the county money), differences in the local population served, etc. In at least two states, advocates believed local agencies are inconsistent in applying standards and client experiences can vary dramatically. At least one state has a problem that local accountability has translated to a focus on timely case processing rather than enrollment or retention as the goal.
- **Information technology in a separate agency.** It is common for states to experience a delay in modifying eligibility data elements because they don't have adequate internal capacity to update information systems. Most work closely with an external information agency which responds to many agencies' needs, but any individual request must be in a queue. One state described a year delay in implementing data elements that could be used for third-party data matching.

- **Concerns about federal audits.** Concerns about penalties that may result from PERM audits prevent some states from pursuing simplifications that are new and untested, such as express lane eligibility and third-party data matching for ex parte renewals.
- **Other agency agendas.** In several of the *Maximizing Enrollment for Kids* states, the public health insurance programs have been trying to reach information sharing agreements with other state agencies in order to find eligible but unenrolled children or reduce the documentation burden on families. These arrangements are advancing very slowly, or not at all, in some states where the other agency does not see health insurance coverage as a core part of its mission. Two states with legislative backing for cross-agency collaboration still find that at the operational level, differences between agencies slow progress.

Opportunities

Based on evidence in the literature and leading states' experiences, these eight states have further opportunities to leverage leadership, capacity, interagency coordination and culture to improve enrollment and retention:

- **Express lane eligibility, ex parte renewal, and other forms of inter-agency collaboration**. As noted under Theme 1, some of the most far-reaching enrollment and renewal opportunities rely on data sharing with other agencies either to identify eligible but uninsured children or use their eligibility data in lieu of family-provided documentation. Louisiana and Illinois have demonstrated the value of third-party data matching at renewal. Both retain over 95 percent of eligible children in coverage using third-party income data in ex parte and administrative renewal processes.

  Several other grantee states are in discussion with sister agencies to identify and enroll children receiving benefits from other state programs who may also be eligible for public health insurance coverage. SNAP is a natural choice for those states who already align SNAP and health insurance enrollment and data. Some of the early steps taken include examining systems' capacity for creating data linkages between programs, creating algorithms for comparing enrollment files, and comparing eligibility criteria. This work may get a boost from the February 2009 CHIPRA legislation which promotes simplified inter-agency coordination through the Express Lane Eligibility provisions. Guidance on this provision is forthcoming from CMS.

  Wisconsin has consolidated health care and nutrition programs under a single umbrella called "ForwardHealth," which includes BadgerCare Plus (Medicaid for children and CHIP), the family planning waiver, Family Care (the Long Term Care Medicaid programs), and FoodShare (Wisconsin's SNAP program). Children have a single, unique identifier in ForwardHealth programs. The agencies have determined which children in each program are eligible for the other, although actual cross-agency enrollment has not occurred. In addition to interagency coordination, families applying for any of these programs in Wisconsin may use a single Internet portal to apply for multiple programs simultaneously.
- **Centralize enrollment and renewal functions.** Coordination problems are much less common when enrollment and renewal functions are handled by the same agency. Further, it is easier to allocate resources efficiently, communicate with staff about agency culture, and create policies that seamlessly move cases between programs when eligibility changes.

- **Seek additional leadership support.** States that do not enjoy good inter-agency relationships may want to seek leadership support, including possibly mandating inter-agency collaboration. States may need to identify champions at the cabinet level or legislature who can facilitate inter-agency partnerships to share data about children. Program leadership may find it useful to educate their legislators about the cost of churning and the potential added efficiencies of agency cooperation and data sharing.
- **Implement simplifications that save staff time.** A number of the simplification strategies discussed in the first part of this paper can lessen the paperwork burden on staff, making it easier for them to be customer-focused and more effective in enrollment and renewal. Churning, for example, is causing staff in some states to re-enroll as many as a third of their caseload each month.
- **Continue to define and communicate expectations to all staff.** Simplification and client-centered service are still relatively new concepts that can conflict with resource constraints. States should maintain or enhance their commitment to eligibility worker training and consider incentives for frontline workers, so that gains are not lost in this stressful period of higher demand. Some states encourage and allow time for workers to assist families more extensively, while others do not. In keeping with the philosophy of performance improvement, states may find it useful to compare performance across enrollment sites, set performance targets, and share best practices when local innovations merit replication.
- **Monitor transfers between Medicaid and CHIP.** In states with separate Medicaid and CHIP eligibility processes or databases, there is a great deal of concern among advocates (and among staff) that children may lose coverage when eligibility changes. States differ in how closely they monitor continuity for children. Several states are monitoring the handoffs, but have been unable to design a process that guarantees children are not lost in transfer. Process maps may be helpful tools for process redesign. In addition, states with a common identifier may be able to evaluate what is happening with a sample of children using their information system. Further, it would be beneficial to involve advocates in this work as they may have insights into what is going wrong for some families.

Theme 4: Consumer, Community Partner, and Stakeholder Engagement

States have undertaken a wide range of activities with entities outside of government in support of improved coverage. Most states have engaged the help of community-based organizations (CBOs) to assist families with enrollment and renewal, and some also encourage health care providers and health plans to assist families as well. In addition, many states have ongoing relationships with advocacy groups, foundations, researchers, and other external stakeholders who can help them with policy development and evaluation. Last, some states engage consumers themselves to provide guidance in process changes so that they fit well with families needs.

Strengths

All states participating in the *Maximizing Enrollment for Kids* Program have promising strategies for partnering with outside entities. Many whom we interviewed credited the CBOs with whom they work for the very high levels of enrollment their state has been able to achieve. They acknowledge that a growing number of families would rather get help in their community than from a government agency. The partnerships that have evolved between the programs and their partners have led to a better fit between consumers' needs and eligibility processes. Some of the strategies that appear to be influential in improving enrollment and retention include:

- **Outreach, enrollment, and renewal assistance:** CBOs are valued community partners helping with outreach, enrollment, and renewal assistance in all eight states, although their number and roles vary. State officials report that community partners have the advantages of being trusted sources of information, familiar with good ways to contact eligible families, available to families at convenient and influential times (such as when seeking medical care for a sick child), and able to speak the same language as the family.

  Further, getting assistance in the community reduces the burden some families would face in seeking out a government-run enrollment site, which may not be convenient with their schedules. Some eligible families may also wish to avoid the stigma of seeking public benefits. Although participating states did not have evidence of their effectiveness, all valued the role that CBOs play and noted upward enrollment trends during the time such partnerships have been in place (although coinciding with many other program changes). States support CBOs by distributing outreach materials, training outreach workers about the programs, and, in some cases, providing information about eligible but uninsured children. States also have provided financial support at times.

  In some states, there are CBOs which get a higher level of training to enhance their ability to complete applications on behalf of families. MassHealth uses Virtual Gateway (VG) Providers, who can be trained and certified to use the Virtual Gateway, a web portal for applying for health and other benefits. VG providers can read copies of letters to applicants from MassHealth and help applicants with any confusion. Enrollment assistors in Wisconsin

> *Entities outside of government play critical roles in bringing the perspectives of families to policy and procedural issues; helping families enroll and renew coverage; generating political support for coverage programs; and providing analysis on which to base further program improvements.*

also have access to account management information. Illinois certifies All Kids Application Agents, and pays them a fee per completed application that results in enrollment. Louisiana also pays application assistors a fee, as did Wisconsin, on a limited basis, during its recent program expansion.

New York uses a wide range of entities as Facilitated Enrollers to assist families in applying for and renewing health insurance coverage. In 2009, 59 CBOs and nearly 15 health plans were authorized facilitated enrollers. Unlike many other states, New York encourages health plans to market Medicaid and Child Health Plus (its CHIP program) and assist applicants in completing and submitting an application. Health Plan enrollment activities are monitored and regulated by the state.

Alabama Medicaid trains and certifies application assisters to complete the application process. Application assisters have been vital for documentation of citizenship and identity, because certified assisters are deputized to view and receive the documentation, and forward the information to Medicaid.

In addition to being of direct help to consumers, application assistors provide some feedback to agencies about the challenges consumers face in successfully completing the enrollment or renewal processes.

- **Providing an environment and infrastructure for policy discussions:** Some states create an environment and infrastructure for people to come together on issues of children's coverage policy. They hold regular meetings with advocates and other policy advisors, such as foundations and researchers, during which information and ideas are exchanged. Some states update the advocacy and policy community on program enrollment, policy changes, and upcoming contract changes. Advocates are provided an opportunity to raise concerns about any problems being reported by families and ask for responses. The dialogue has been credited with improving the programs and garnering legislative support for changes which the agencies cannot achieve on their own.

  The Virginia legislature created the Children's Health Insurance Program Advisory Committee (CHIPAC) in 2004 as a forum for policy stakeholders to focus on children's health insurance coverage.

  In New York, the United Hospital Fund's Medicaid Institute and the New York State Health Foundation convene state officials, researchers, advocates, practitioners, and plans on a regular basis to discuss coverage issues. Many valuable studies funded under the auspices of the Foundations later play a role in simplifying enrollment and retention. For example, one recent study recommended simplifications to eligibility categories which have since been incorporated into policy.

  Other states have ad hoc meetings with smaller groups to exchange information and ideas related to specific initiatives.

- **Seeking consumer input.** Many states (or their research partners) have held focus groups of enrolled or eligible families to learn if the program is working well for them, or if proposed changes would be accepted. For example, the BadgerCare Plus program in Wisconsin tested the online tool with families before fully implementing it. The Children's Defense Fund, The Community Service Society and the Coalition of New York State Public Health Plans with support from the United Hospital Fund and other foundations are examining changes needed

to New York's application before the face-to-face interview is made optional in 2010. Through consumer focus groups, the state has learned what wording is particularly confusing and results are being put to use in the application redesign. Other states use disenrollment surveys to learn more about barriers to retaining coverage.

- ***External support for data analysis and outreach.*** Several states have benefitted from partnerships with local universities and foundations interested in covering children. These foundations have supported data collection and analysis that helps in program decision-making. The University of Wisconsin and Louisiana State University conduct the household insurance surveys in their respective states, providing uninsured estimates and their characteristics. The University of Alabama at Birmingham, School of Public Health has assisted Alabama's CHIP with enrollment-related studies. The Virginia Healthcare Foundation (through a contract with Virginia DMAS) provides funds and training for Virginia's Project Connect outreach workers.

Challenges

Some of the limits of community and stakeholder partnerships were related to financial constraints in state and local governments, and the diminishing ability to find the remaining uninsured. Schools, which seem to be a likely place to enroll eligible children, cannot produce information on the insurance status of children as readily as they, and their outreach partners, would like. The most often mentioned challenges were:

- **Financial constraints facing CBOs**. During site visits, most CBOs whom we interviewed felt as if their effectiveness was somewhat limited by their budgets. Because of the recession, their caseloads were high and resources scarce. Some described delays as long as a month to see a potentially eligible family. Some who had received financial support from the state in the past anticipated outreach grants being cut in the future.
- **Few CBOs in some areas, or none representing key groups.** While large cities tend to have multiple, established CBOs who are able to help their clients with health insurance, some states and large cities have very few groups. As new immigrant groups move to a state, the program staff sometimes has trouble finding contacts from the community.
- **Hard-to-identify and underserved groups.** In states with very low numbers of uninsured children, CBOs noted how hard it was to know where to look for the remaining uninsured. Migrant families, rural families with limited access to the Internet or commercial media, children living with non-parental custodians and teenagers who have dropped out of school are among the difficult to reach and enroll populations among grantee states. In addition, some underserved groups were hard to reach due to limitations in the states' relationships. For example, in some states with Native American tribes, partnerships were noted as developing slowly.
- **Limitations of school partnerships.** Community partners and program leaders noted that it is technically difficult to match school data with health insurance enrollment to identify uninsured children. Records are often kept by local school districts and on paper. School staff cannot be diverted from their core functions to make data available. Even in districts that have partnered with health insurance programs, many families did not follow up in response to outreach efforts.

- **Advocates seeking more structure.** Advocates generally were very complimentary of these states' program staff, but in some cases, wanted more structured opportunities to meet and get program updates.

Opportunities

Based on evidence in the literature and leading states' experiences, these states may consider these approaches:

- **Shift some stakeholder resources to renewal.** Some states lose one-quarter to one-half of children at renewal. These are children who should be easier to find and help, as some contact information is available through the eligibility database or a managed care plan. States may want to collaborate with community partners to develop ways in which assistors can reduce churning at renewal, or outreach in a more targeted way to families who have lost coverage.
- **Seek additional outreach funds.** States may want to seek or support their community partners or American Indian/Native Alaskan tribal organizations in seeking grants available for outreach and enrollment, such as from CMS in the coming cycles of CHIPRA Outreach Grants or from local foundations.
- **Engage consumers in helping to simplify and streamline.** States that are considering policy or process changes should invite consumer input to increase the likelihood of success.
- **Hold stakeholder meetings**. States which currently lack a structure for getting stakeholder input may want to schedule periodic meetings with advocates who can share important information not available inside the agency. This strategy can help build support for the program, which may be needed in protecting its resources during difficult budget times.
- **Assess potential for partnerships with entities serving as medical homes.** Over half of states are working on medical home models of coordinating care for children enrolled in Medicaid and CHIP. States may want to build renewal assistance for these children into the responsibilities of the medical home provider.
- **Evaluate the effectiveness of new initiatives.** Foundations and researchers can help states obtain valuable data on the effectiveness of community outreach and enrollment, and on the effects of policy changes on coverage. Partnering with a university or foundation, and possibly getting federal matching funds for this work, could greatly help program staff and legislators in their decisions.

Conclusions

This diagnostic assessment of enrollment and retention systems for the eight states participating in *Maximizing Enrollment for Kids* has helped identify numerous ways in which policies and programs are promoting the enrollment and retention of eligible children in Medicaid and CHIP. Each of the eight states has made program simplifications so that eligible children are less likely to experience administrative barriers. States report that these efforts have also helped reduce staff workload so that more applications and renewals can be processed with the same or smaller-sized staffs. Many, though not all, grantee states are working with legacy systems or designing new information systems

to monitor program effectiveness. The ability to track children over time as they move across programs and in and out of coverage is essential to assuring eligible children do not lose coverage for administrative reasons.

Each of the eight grantee states has worked to align Medicaid and CHIP policies and processes, sometimes within one agency but more often across at least two agencies, so that families can more readily navigate eligibility and renewal processes. Partnerships between the agencies that set policy and the agencies that conduct eligibility determinations have helped with coordination, particularly when children transition between programs. Furthermore, the work of Medicaid and CHIP agencies is being supported by governors, legislators, and other policymakers to promote interagency collaboration. And to further the effectiveness of this work, agencies are promoting an organizational culture that fosters customer-centered processes.

Finally, Medicaid and CHIP agencies are engaging entities outside government to play critical supporting roles as partners, both in improving the way the program works for families and in advocating for stronger policies. CBOs, advocates, and consumers themselves have helped strengthen enrollment and retention policies and processes in numerous ways.

Even while many positive improvements are underway, the assessment identified several common barriers to enrollment and retention. Producing documentation at application and renewal is still too difficult for many families, and the percentage that never completes the enrollment or renewal process is relatively high in many grantee states. Those using third-party data in lieu of some or all documentation, however, report higher retention rates, making this strategy a promising practice for other states to consider.

Some states have coordination problems when children's eligibility changes and their enrollment status must be transferred from Medicaid to CHIP or vice versa. Older information systems, new documentation requirements, and incomplete handoffs can cause eligible children to lose coverage.

Advocates in most grantee states expressed concerns that despite agency efforts, not all enrollment sites are equally customer-centered. Staff attitudes toward clients and process complexity have deterred some families, suggesting that more work is needed to implement policies evenly within each state and monitor progress.

The lessons learned from these states may serve instructive as policymakers develop and implement national health system reform. As states and the federal government seek effective strategies to identify, enroll, and retain new populations and those currently eligible into expanded public health coverage programs and new subsidies, this report offers many critical take home lessons about the benefits of simplification, the importance of sound data collection and monitoring systems and strategies, the vital role that leadership and agency relationships and culture play, and the added value of involving consumers, community organizations and other stakeholders in the process. The report also notes some of the challenges even leading states' public coverage systems continue to face, identifying pitfalls that new coverage systems should seek to redress and avoid where possible. As grantee states move forward in their efforts, *Maximizing Enrollment for Kids* will continue to report on lessons learned and best practices that other states and other programs can replicate to improve their enrollment efforts.

Participating in this assessment, including seeking to provide data and mapping enrollment and renewal processes, has provided states with some new insight into their programs and policies. Some report the work helped identify or confirm key next steps as states continue to pursue their coverage

goals with additional support from the *Maximizing Enrollment for Kids* program. Going forward, these states are looking to implement a number of innovative and promising strategies that could provide additional best practice ideas for policymakers in the years ahead. Among the key strategies that a most grantee states are planning to test as part of the *Maximizing Enrollment for Kids* program are:

- **Implementation of Express Lane Enrollment initiatives:** Nearly all grantee states are looking to implement some form of express lane enrollment, which will enable them to borrow eligibility determinations from other agencies or programs in determining children's eligibility for Medicaid or CHIP;
- **Implementation of the new Social Security Number Citizenship Documentation Option under CHIPRA:** According to a recent Kaiser Family Foundation survey, nearly two-fifths of the states are considering implementing this new option to document citizenship and identity in lieu of requiring individuals to present traditional documentation like birth certificates, passports and other formal documents.[4] States will move forward with these efforts once further guidance has been provided by CMS and the Social Security Administration.
- **Using focus groups to obtain feedback on system barriers:** Nearly all grantee states are seeking more direct feedback from families, community-based organizations, state workers, and others relating to perceptions about children's coverage and barriers to enrollment and retention.
- **Using data more strategically to monitor and inform performance:** All grantee states will be investing in their capacity to collect, analyze and use data on an ongoing basis to inform policy decisions related to enrollment and retention of children.

Opportunities for Other States

In addition to learning from the experiences of the grantee states, other states can learn more about their own strengths, challenges and opportunities by conducting their own diagnostic assessment of enrollment and retention systems, policies, and procedures using the same approach taken with grantee states. On the *Maximizing Enrollment for Kids* website (www.maxenroll.org), states will find tools to help them evaluate their own progress by completing four steps:

1. Map the enrollment and renewal processes for children's health insurance coverage to identify barriers and opportunities to streamline from both the family's and the worker's perspective.
2. Complete a questionnaire about current practices and policies, which will generate a list of new opportunities for consideration.
3. Interview stakeholders using the guides developed for the grantee states. Interview guides are available for policymakers (Governor's staff, legislators, or legislative assistants; advocates; and community-based organizations and other enrollment assistors).
4. Identify next steps, either within the agency or as part of a larger stakeholder meeting.

States and interested policymakers should contact NASHP for help with the self-assessment toolkit or with any questions about the assessment or the program.

[4] Cohen Ross, D., et al., "A Foundation for Health Reform: Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents During 2009." The Henry J. Kaiser Family Foundation, December 2009

Appendix I:

Table 1. Characteristics of Children's Health Insurance Programs in *Maximizing Enrollment for Kids* States

	Alabama	Illinois	Louisiana	Massachusetts	New York	Utah	Virginia	Wisconsin
Program Management								
Medicaid Program	SOBRA Medicaid	All Kids[5]	LaCHIP/ Medicaid	MassHealth	Medicaid	Medicaid	FAMIS Plus	BadgerCare Plus
Separate CHIP Program	ALL Kids		LaCHIP Affordable Plan		Child Health Plus (CHP)	Children's Health Insurance Program	FAMIS	
Enrollment Conducted by Local Employees	N	N[6]	N	N	Y	N	Y	Y
Additional entity or agency determines Medicaid and/or CHIP Eligibility	N	Y	N	N	Y	Y	Y	N
Enrollment Statistics (2007-2008)[7]								
Uninsured Children	70,500	235,400	140,300	49,000	388,600	94,500	182,800	82,100
% Uninsured Children	5.9	7.0	12.0	3.2	8.3	10.6	9.3	5.8
Children in Medicaid[8]	385,900	1,298,600	586,100	360,100	1,624,800	106,700	370,400	381,800
Children in CHIP[9]	71,300	186,100	124,300	110,300	365,300	35,200	107,300	69,800
Uninsured Children Below 200 Percent FPL[10]	48,000	154,000	95,000	20,000	216,000	45,000	96,000	46,000
% Uninsured Children Below 200 Percent FPL[10]	67.6	66.4	67.4	40.0	56.0	48.4	53.3	57.5

[5] All Kids includes state-funded and federally-funded children.
[6] Eligibility is determined locally and at a centralized eligibility unit by state employees.
[7] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on March 2008 and 2009 Current Population Survey (CPS: Annual Social and Economic Supplements). States also have their own estimates of the uninsured based on other methodologies that consider Medicaid enrollment. For consistency, this table reports data using the Urban Institute data.
[8] December 2008 data. Compiled by Health Management Associates from state Medicaid enrollment reports, for the Kaiser Commission on Medicaid and the Uninsured, 2009.
[9] June 2008 data. Compiled by Health Management Associates from state Medicaid enrollment reports, for the Kaiser Commission on Medicaid and the Uninsured.
[10] SHADAC estimates based on March 2008 and 2009 Current Population Survey (CPS: Annual Social and Economic Supplements).

Renewal Statistics								
Renewal Rates for children in Medicaid/CHIP	N/A/(59.2)	95	99	58	70 / 76	58 / 59	N/A	N/A
Upper Income Limit (Medicaid / CHIP)								
Birth to Age 1	133 / 200[11]	200[12]	133 / 200 / 250[13]	200 / 300	200 / 400	133 / 200	133 / 200	300 / 300
Ages 1 to 5	133 / 200[11]	133 / 200[12]	133 / 200 / 250	150 / 300	133 / 400	133 / 200	133 / 200	185/250
Ages 6 to 19	100 / 200[11]	133 / 200[12]	133 / 200 / 250	150 / 300	100/ 400	100 / 200	100 /133/ 200[14]	100/250
CHIP Program Eligibility Rules								
Waiting Period (Months)	3[15]	0[16]	12	6[17]	6[18]	3	4	3 / 12[19]
Income Level at Which Premiums Begin (FPL)	101	151	201	150[20]	160	101	None	201[21]
Enrollment Simplification Policies (Medicaid / CHIP)								
Joint Medicaid / CHIP Application	Y	Y	Y	Y	Y	Y	Y	Y
Universal Application (w/ other public programs)	N	Y	N	Y	Y	Y	N	Y
Mail / Fax Application	Y	Y	Y	Y	N	Y	Y	Y
Online Application	Y	Y	Y	Y	N	Y	Y	Y
Administrative Income Verification	Y/N	Y/N[22]	N	Y	N	N	N	Y
Administrative Birth Record Verification	N	Y[23]	Y[23]	Y	N	Y	Y	Y[23]

[11] Eligibility for ALL Kids was expanded to 300% FPL, effective October of 2009.

[12] Illinois has a state plan amendment pending with the Centers for Medicare and Medicaid Services that would expand eligibility under federally-funded programs to 500% FPL.

[13] Children are insured up to 250% of FPL through a separate state SCHIP program (LaCHIP Affordable Plan, implemented in 2008).

[14] Virginia's Medicaid eligibility is 100% FPL; Virginia's CHIP program increases eligibility to 133% FPL through a Medicaid expansion and from 133% FPL to 200% FPL through a separate CHIP program.

[15] If health insurance is voluntarily dropped by the parent or legal guardian, there is a 3-month waiting period before the child may apply for ALL Kids. Some exclusions (e.g. COBRA, individual coverage, life time max.) may apply.

[16] Illinois' waiting period only applies to children whose family income exceeds 200% FPL. There is no waiting period for children whose family income is at or below 200% FPL.

[17] Massachusetts' 6-month waiting period is only for children with family incomes between 200-300% of FPL who indicated that they had access to insurance within the past 6 months. It is part of the Commonwealth's crowd-out provision that arose from the state's health reform legislation.

[18] New York only has a waiting period for children in the expansion category (251-400% FPL) whose families drop employer-sponsored coverage to take CHPlus.

[19] 3 and 12 month waiting periods are situation dependent. See BadgerCare Handbook (section 7.8). http://www.emhandbooks.wi.gov/bcplus/

[20] Waived if a parent has a premium for other public coverage.

[21] Premiums for children start at family incomes greater than 200% FPL. Premiums for parents start at 150% FPL.

[22] Illinois uses partial administrative income verification – eligibility workers have access to benefits received through Social Security and Illinois unemployment offices.

[23] For children born in-state.

No Asset Test	Y	Y	Y	Y	Y	Y/N[24]	Y	Y
Self-Declaration of Income	Y[25]	N	N	N	N	N	N	Y
Presumptive Eligibility	N	Y	N[26]	Y	Y[27]	N	N	Y[28]
Renewal Simplification Policies								
Frequency of Renewal (Months)	12	12	12	12	12	6 / 12	12	12
Continuous Eligibility (12 Months)	Y	Y	Y	N	Y	N / Y	N / Y	N
Ex Parte Renewal	N	N	Y	N	N	N	Y / N	N
Administrative Renewal	Y/N	Y[29]	Y	N	N	N	N	N
Online Renewal	Y[30]	N	Y[25]	N[31]	N	N	Y[32]	Y (forthcoming)
Pre-printed Renewal Forms	Y	Y	N	N[32]	Y	Y	N / Y	N

24 No asset test is required in Medicaid for children under 6 or for children in CHIP.
25 Verification is required for self-employment income.
26 Not yet fully implemented.
27 Medicaid presumptive eligibility may only be determined by FQHCs.
28 For families up to 150 percent of FPL.
29 For families up to 200 percent of FPL.
30 Not yet fully implemented.
31 Massachusetts does not provide a preprinted renewal form or online renewal for MassHealth children. Both are available to Commonwealth care members only; Verification is required for self-employment income.
32 In process.